1996

GUIDE

To Health Insurance for People with Medicare

- ★ WHAT MEDICARE PAYS AND DOESN'T PAY
- ★ 10 STANDARD MEDIGAP INSURANCE PLANS
- ★ YOUR RIGHT TO MEDIGAP INSURANCE
- ★ THE MANAGED CARE OPTION
- ★ TIPS ON SHOPPING FOR PRIVATE HEALTH INSURANCE

Developed jointly by the
National Association of Insurance Commissioners
and the
Health Care Financing Administration of the U.S. Department of Health and Human Services

– NOTICE –

Listed in the back of this booklet are the addresses and telephone numbers of each of the state agencies on aging and the state insurance departments. They are available to assist you with any questions you may have about private insurance to supplement Medicare.

Suspected violations of the laws governing the marketing of insurance policies should generally be reported to your state insurance department since states are responsible for the regulation of insurance within their boundaries.

There are, however, federal penalties for certain violations concerning Medicare supplement insurance ("Medigap") policies. It is, for example, a federal offense for an insurance agent to indicate that he or she represents the Medicare program or any other federal agency in order to sell a policy. It is also illegal for an insurance company or agent to sell you a second Medigap policy unless you indicate in writing that you intend to terminate your existing Medigap policy.

The federal toll-free telephone number for filing complaints is:

1-800-638-6833

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DEFINITIONS OF SOME MEDICARE TERMS

Actual Charge: The amount a physician or supplier actually bills for a particular medical service or supply.

Approved Amount: The amount Medicare determines to be reasonable for a service that is covered under Part B of Medicare. It may be less than the actual charge. For many services, including physician services, the approved amount is taken from a fee schedule that assigns a dollar value to all Medicare-covered services that are paid under that fee schedule.

Assignment: An arrangement whereby a physician or medical supplier agrees to accept the Medicare-approved amount as full payment for services and supplies covered under Part B. Medicare usually pays 80% of the approved amount directly to the physician or supplier after the beneficiary meets the annual Part B deductible of $100. The beneficiary pays the other 20%.

Benefit Period: A benefit period is a way of measuring a beneficiary's use of hospital and skilled nursing facility services covered by Medicare. A benefit period begins the day the beneficiary is hospitalized. It ends after the beneficiary has been out of the hospital or other facility that primarily provides skilled nursing or rehabilitation services for 60 days in a row. If the beneficiary is hospitalized after 60 days, a new benefit period begins, most Medicare Part A benefits are renewed, and the beneficiary must pay a new inpatient hospital deductible. There is no limit as to the number of benefit periods a beneficiary can have.

Coinsurance: The portion or percentage of the Medicare-approved amount that a beneficiary is responsible for paying.

Deductible: The amount of expense a beneficiary must first incur before Medicare begins payment for covered services.

Excess Charge: The difference between the Medicare-approved amount for a service or supply and the actual charge, if the actual charge is more than the approved amount.

Limiting Charge: The maximum amount a physician may charge a Medicare beneficiary for a covered physician service if the physician does not accept assignment of the Medicare claim. The limit is 15% above the fee schedule amount for non-participating physicians. Limiting charge information appears on Medicare's Explanation of Medicare Benefits (EOMB) form.

Medicare Carrier: An insurance organization under contract to the federal government to process Medicare Part B claims from physicians and other suppliers. The names and addresses of the carriers and areas they serve are listed in the back of *The Medicare Handbook*, available from any Social Security Administration office.

Medicare Hospital Insurance: This is Part A of Medicare. It helps pay for medically necessary inpatient care in a hospital, skilled nursing facility or psychiatric hospital, and for hospice and home health care.

Medicare Medical Insurance: This is Part B of Medicare. This part helps pay for medically necessary physician services and many other medical services and supplies not covered by Part A.

Participating Physician and Supplier: A physician or supplier who agrees to accept assignment on all Medicare claims.

SOME BASIC THINGS YOU SHOULD KNOW

If you are like most persons covered by Medicare, there are aspects of the federal health insurance program that you find complex and confusing. You may be uncertain about what Medicare covers and doesn't cover and how much it pays toward your medical expenses. And, like many other beneficiaries, you want to know what, if any, additional health insurance you should buy.

This guide has been developed jointly by the National Association of Insurance Commissioners (NAIC) and the Health Care Financing Administration (HCFA) of the U.S. Department of Health and Human Services (DHHS). It will provide you with information that will help you make the health insurance choices that are right for you. While it does not recommend any particular insurer or policy, it does:

- Explain your Medicare benefits;
- Identify the gaps in your Medicare coverage;
- Describe the various types of insurance available to supplement your Medicare coverage;
- Provide tips on shopping for private health insurance, and
- List the names and telephone numbers of state agencies available to answer your questions about health insurance.

Covering Medicare's Gaps

You probably are already aware that there are some health care costs that Medicare does not fully cover or does not cover at all. In addition to Medicare's deductibles, you have to pay a share of the cost for covered services and the full amount for services not covered by Medicare. Other than paying these bills out-of-pocket, which few people can afford, there are four basic ways to fill the gaps in Medicare:

1. By buying Medicare supplement insurance, which may also be called "Medigap" insurance.
2. By enrolling in a managed care plan, such as a health maintenance organization (HMO) that has a Medicare contract.
3. By continuing coverage under an employer-provided health insurance policy, if you are eligible for such protection.
4. By either qualifying for full Medicaid benefits or for at least some state assistance in paying your Medicare costs.

Each of these ways will be discussed in subsequent sections. Special attention will be devoted to employer plans and Medigap insurance. As you explore the various options for filling the gaps in your Medicare coverage, carefully evaluate your needs and ability to pay the premiums before deciding on a plan.

What To Do First

Before buying additional insurance, you should:

- ☑ Review any insurance you already have, such as employer-paid coverage, to see what, if any, additional insurance you need and can afford.
- ☑ If you have a low income and limited resources, check with your state to see whether you qualify for Medicaid or for other state help in paying your health care costs (see page 23). A few states have programs that help pay for prescription drugs and other medical services. You can find out if yours does by contacting the state office that provides insurance counseling.

Insurance Counseling

Each state offers insurance counseling in one-on-one confidential sessions with trained counselors. In these sessions, you will be able to clarify insurance issues that you find confusing and receive assistance in evaluating your insurance needs. These services are free. The telephone number for your state insurance counseling office is listed in the di-

rectory of state insurance departments and agencies on aging beginning on page 27.

Before discussing Medigap and the other types of private insurance available to supplement Medicare, it will be helpful to review your Medicare benefits and identify the payment gaps.

WHAT IS MEDICARE?

Medicare is a federal health insurance program for:

- people 65 or older,
- people of any age with permanent kidney failure, and
- certain disabled people under 65.

Medicare is administered by the Health Care Financing Administration. The Social Security Administration provides information about the program and handles enrollment. If you are receiving Social Security or Railroad Retirement Board benefits when you turn 65, you are enrolled in Medicare automatically and will receive your Medicare card in the mail. If you are not receiving benefits when you turn 65, you must contact a Social Security Administration office or, if appropriate, the Railroad Retirement Board. If you are disabled, you will automatically get a Medicare card in the mail when you have been a disability beneficiary under Social Security or Railroad Retirement for 24 months.

Two Parts of Medicare

The Medicare card shows the Medicare coverage you have—Hospital Insurance (Part A), Medical Insurance (Part B), or both—and the date your coverage started. If you have only one part of Medicare, you can get information about getting the other part from any Social Security Administration office.

Part A. Medicare Part A is financed by part of the Social Security payroll withholding tax paid by workers and their employers, and by part of the Self-Employment Tax paid by self-employed persons. If you or your spouse is entitled to benefits under either the Social Security or Railroad Retirement systems or worked long enough in federal, state or local government employment to be insured, you do not have to pay a monthly premium for Part A. Your Part A coverage generally starts in the month you turn 65 or shortly thereafter, depending on when you apply.

Buying Part A: If you do not qualify for premium-free Part A benefits, you may buy the coverage if you are at least 65 years old and meet certain requirements. You also may buy Part A if you are under age 65, were previously entitled to Medicare under the disability provisions and still have the same disabling impairment but your disability benefits were terminated because of your work and earnings. The monthly Part A premium in 1996 is $188 if you had at least 30 quarters of Medicare-covered employment but fewer than 40 quarters. It is $289 if you had fewer than 30 quarters or no quarters of covered employment.

Part B: Medicare Part B is paid for in part by the premiums from persons who enroll in the program. The monthly premium in 1996 is $42.50, and most enrollees have it deducted from their monthly Social Security check. You are automatically enrolled in Part B when you become entitled to premium-free Part A unless you state that you don't want it. Although you do not have to buy Part B, it is generally a good deal because the federal government subsidizes about 75 percent of the program costs. Even if you do not qualify for premium-free Part A, you generally can buy Part B if you are 65 or older.

Medicare Enrollment Periods: The initial enrollment period for Part B and premium Part A runs for seven months beginning three months before the month in which you turn 65. If you do not enroll during your initial 7-month enrollment period, you will have to wait until the next "general enrollment period." These enrollment periods occur each year, from January 1 through March 31. Coverage begins the following July 1.

Premiums for both Part A and Part B generally will be higher if you wait to enroll during a general enrollment period. The Part B premium goes up 10 percent for each 12 months after you were first eligible. So, if you wait 24 months to enroll in Part B,

your premium will always be 20 percent higher. The increase in the Part A premium (if you have to pay a premium) is limited to 10 percent no matter how late you enroll for the coverage.

Under certain circumstances, however, you can delay your enrollment without having to pay higher premiums. Specifically, if you are 65 or over and have group health insurance based on your or your spouse's current employment, you have a choice as to when to enroll in Medicare. You may enroll at any time you are covered under the group health plan or you may wait and enroll during a special eight-month enrollment period. It begins the month you or your spouse stops working or when you are no longer covered under the employer plan, whichever comes first. If you do not enroll during this special enrollment period, you will have to wait until the next general enrollment period.

Medigap Warning: Be aware that your Medigap open enrollment period, which is a period of time during which you can buy the Medigap policy of your choice, starts as soon as you enroll in Part B and are 65 or older (see page 16).

MEDICARE HOSPITAL INSURANCE BENEFITS (PART A)

When all program requirements are met, Medicare Part A helps pay for medically necessary inpatient care in a general hospital, skilled nursing facility, psychiatric hospital or hospice care. In addition, Part A pays the full cost of medically necessary home health care and 80 percent of the approved cost for wheelchairs, hospital beds, and other durable medical equipment (DME) supplied under the home health care benefit. Coverage is also provided for whole blood or units of packed cells, after the first three pints, when furnished by a hospital or skilled nursing facility during a covered stay.

Benefit Periods

Medicare hospital and skilled nursing facility benefits are paid on the basis of benefit periods. A benefit period begins the first day you receive a Medicare-covered service in a qualified hospital. It ends when you have been out of a hospital or other facility that primarily provides skilled nursing or rehabilitation services for 60 days in a row. It also ends if you remain in a facility (other than a hospital) that primarily provides skilled nursing or rehabilitation services but do not receive any skilled care there for 60 days in a row.

If you enter a hospital again after 60 days, a new benefit period begins. With each new benefit period, Part A hospital and skilled nursing facility benefits are renewed except for any lifetime reserve days or psychiatric hospital benefits you used. There is no limit to the number of benefit periods you can have for hospital or skilled nursing facility care.

Inpatient Hospital Care

If you are hospitalized, Medicare will pay for all covered hospital services during the first 60 days of a benefit period, except for the deductible. The Part A deductible in 1996 is $736 per benefit period. You are responsible for the deductible.

In addition to the deductible, you are responsible for a share of the daily costs if you are hospitalized for more than 60 days in a benefit period. For the 61st through the 90th day, Part A pays for all covered services except for coinsurance of $184 a day in 1996. You are responsible for the coinsurance.

Under Part A, you also have a lifetime reserve of 60 days for inpatient hospital care. These lifetime reserve days may be used whenever you are in the hospital for more than 90 days in a benefit period. When a reserve day is used, Part A pays for all covered services except for coinsurance of $368 a day in 1996. Again, the coinsurance is your responsibility. Once used, reserve days are not renewed.

Gaps In Inpatient Hospital Coverage

You Pay:

- $736 deductible on first admission to hospital in each benefit period.
- $184 daily coinsurance for days 61 through 90.
- All charges for coverage after 90 days in any benefit period unless you have "lifetime reserve" days available and use them.

(over)

- $368 daily coinsurance for each lifetime reserve day used.
- For the first three pints of whole blood or units of packed cells used in each year in connection with covered services unless the blood is replaced. To the extent the blood deductible is met under one part of Medicare, it does not have to be met under the other part.
- For a private hospital room, unless medically necessary, and for a private duty nurse.
- For personal convenience items, such as a telephone or television in a hospital room.
- For non-emergency care in a hospital that does not participate in the Medicare program.
- For care received outside the United States and its territories, except under limited circumstances in Canada and Mexico.

Psychiatric Hospital Care

Medicare Part A helps pay for no more than 190 days of inpatient care in a Medicare-participating psychiatric hospital in your lifetime. Once you have used 190 days, Part A doesn't pay for any more inpatient care in a psychiatric hospital. However, psychiatric care provided in a general hospital, rather than in a psychiatric hospital, is not subject to the 190-day limit.

If you are a patient in a psychiatric hospital on the first day of your entitlement to Medicare, there are additional limitations on the number of hospital days that Medicare will pay for. Inpatient psychiatric care is subject to the same terms and conditions as other Medicare inpatient hospital care.

Gaps In Inpatient Psychiatric Hospital Coverage You Pay:

- For all care after you have received 190 days of such specialized treatment in your lifetime (even if you have not yet exhausted your coverage for inpatient care in a general hospital).
- The gaps in general hospital coverage also apply to psychiatric hospital coverage.

Skilled Nursing Facility Care

To qualify for Medicare-covered skilled nursing facility (SNF) benefits, you must:

- ☑ Require daily skilled care which, as a practical matter, can only be provided in a skilled nursing facility on an inpatient basis.
- ☑ Be in the hospital for at least three consecutive days (not counting the day of discharge) before entering a skilled nursing facility that is certified by Medicare.
- ☑ Be admitted to the skilled nursing facility for the same condition for which you were treated in the hospital.
- ☑ Generally be admitted to the facility within 30 days of your discharge from the hospital.
- ☑ Be certified by a medical professional as needing skilled nursing or skilled rehabilitation services on a daily basis.

Medicare Part A can help pay for up to 100 days of skilled care in a skilled nursing facility during a benefit period. All covered services for the first 20 days of care are fully paid by Medicare. All covered services for the next 80 days are paid by Medicare, except for a daily coinsurance amount. The daily coinsurance in 1996 is $92. You are responsible for the coinsurance. If you require more than 100 days of care in a benefit period, you are responsible for all charges beginning with the 101st day.

A skilled nursing facility is different from a nursing home. It is a special kind of facility that primarily furnishes skilled nursing and rehabilitation services. It may be a separate facility or a distinct part of another facility such as a hospital.

Medicare will not pay for your stay if the services you receive are primarily personal care or custodial services, such as assistance in walking, getting in and out of bed, eating, dressing, bathing and taking medicine.

Gaps In Skilled Nursing Facility Coverage

You Pay:

- $92 daily coinsurance for days 21 through 100 in each benefit period.
- All costs for care after 100 days in a benefit period.
- All costs for care that is less than the level of care Medicare covers in a SNF.
- All costs if you were not transferred to the SNF in a timely manner after a qualifying hospital stay.
- For care in a general nursing home, or in a SNF not approved by Medicare, or for just custodial care in a Medicare-approved SNF.
- The 3-pint blood deductible (see list of gaps under inpatient hospital care on page 4).

Home Health Care

Medicare pays the full cost of medically necessary home health visits by a Medicare-approved home health agency. A home health agency is a public or private agency that provides skilled nursing care, physical therapy, speech therapy and other therapeutic services in the patient's home. These services are usually provided on a periodic basis by a visiting nurse and/or home health aide.

To qualify for coverage, you have to need intermittent skilled nursing care, physical therapy, or speech therapy, be confined to your home, and be under a physician's care. You do not have to pay a deductible or coinsurance (except for durable medical equipment), and no prior hospitalization is required for home health care benefits. Medicare will also cover a portion of the cost of wheelchairs, hospital beds and other durable medical equipment (DME) provided under a plan-of-care set up and periodically reviewed by a physician.

Gaps in Home Health Coverage

You Pay:

- For full-time nursing care.
- For meals delivered to your home and for drugs.
- Twenty percent of the Medicare-approved amount for durable medical equipment, plus charges in excess of the approved amount on unassigned claims.
- For homemaker services that are primarily to assist you in meeting personal care or housekeeping needs.

Hospice Care

Medicare pays for hospice care for terminally ill beneficiaries who choose to receive hospice care rather than regular Medicare benefits for management of their illness. Under Medicare, hospice is primarily a program of care generally provided in the patient's home by a Medicare-approved hospice. The focus is on care, not cure. Hospice services covered under Medicare Part A include:

- ☑ Physician services
- ☑ Nursing care
- ☑ Medical appliances and supplies
- ☑ Drugs (for pain and symptom relief)
- ☑ Short-term inpatient care
- ☑ Medical social services
- ☑ Physical therapy, occupational therapy and speech/language pathology services
- ☑ Dietary and other counseling

There is no deductible for these hospice care benefits. Copayments are, however, required for the following two benefits:

1. Prescription drugs for pain relief and symptom management, for which patients can be charged 5% of the reasonable cost, but no more than $5 for each prescription.

(over)

2. Respite care, for which the patient can be charged about $5 per day, depending on the area of the country. Inpatient respite care provides some time off for the person who regularly provides care in the home. Each stay is limited to no more than five days.

If you need medical services for a condition unrelated to the terminal illness, regular Medicare benefits are available. When regular benefits are used, you are responsible for the applicable Medicare deductible and coinsurance amounts.

Gaps In Hospice Coverage

You Pay:

- Limited charges for inpatient respite care and outpatient drugs.
- Deductibles and coinsurance amounts when regular Medicare benefits are used for treatment of a condition other than the terminal illness.

MEDICARE MEDICAL INSURANCE BENEFITS (PART B)

Medicare pays for a wide range of medical services and supplies, but the most significant coverage is for your doctor's bills. Medically necessary physician services are covered no matter where you receive them—at home, in the doctor's office, in a clinic, in a nursing home, or in a hospital. Part B also covers:

- ☑ Outpatient hospital services
- ☑ X-rays and laboratory tests
- ☑ Certain ambulance services
- ☑ Durable medical equipment, such as wheelchairs and hospital beds, used at home
- ☑ Services of certain specially qualified practitioners who are not physicians
- ☑ Physical and occupational therapy
- ☑ Speech/language pathology services
- ☑ Partial hospitalization for mental health care
- ☑ Mammograms and Pap smears
- ☑ Home health care if you do not have Part A

While Part B generally does not cover outpatient prescription drugs, it does cover some oral anticancer drugs, certain drugs for hospice enrollees, and non-self-administrable drugs provided as part of a physician's services. Certain drugs furnished during the first year after an organ transplantation and epoetin for home dialysis patients are also covered, as well as antigens, and flu, pneumococcal, and hepatitis B vaccines. Coverage is also provided for blood after you meet the 3-pint annual deductible.

Part B Deductible And Coinsurance

When you use your Part B benefits, you will be required to pay the first $100 each calendar year. This is called the deductible. It must be based on the Medicare-approved amount for covered services and supplies, not the actual charges billed by your physician or medical supplier.

After you meet the deductible, Part B generally pays 80 percent of the Medicare-approved amount for all covered services you receive during the rest of the year. You are responsible for the other 20 percent. Your 20 percent share is called coinsurance. If you require home health services under Part B, you do not have to pay a deductible or coinsurance. You do, however, have to pay 20 percent of the Medicare-approved amount for any durable medical equipment supplied under the home health benefit.

Besides the deductible and coinsurance, you may also have other out-of-pocket costs if your physician or medical supplier does not accept assignment of your Medicare claim and charges more than Medicare's approved amount. The difference to be paid is called the "excess charge."

Medicare-Approved Amount

The Medicare-approved amount for physician services covered by Part B is based on the lesser of the physician's actual charge or the fee schedule amount. The fee schedule assigns a dollar value to each physician service based on work, the cost of running a

practice and malpractice insurance costs. Medicare generally pays 80 percent of the approved amount.

Here's how the payment system works. Let's suppose you go to a physician who accepts assignment of your Medicare claim and the approved amount for the services you receive is $100. Let's also assume that you have met your $100 deductible for the year. Medicare would pay the doctor $80 and you would be responsible for the $20 balance.

If you went to a physician who does not accept assignment, you would have to pay more. Using the $100 example above, the approved amount would be $95 because the approved amount for physicians that do not accept assignment is 95 percent of the amount for those that do. Also, non-participating physicians can bill an excess charge up to 15 percent of the approved amount. Therefore, you would have to pay 20 percent of the approved amount, or $19, plus the excess charge of $14.25. This means that you would pay $13.25 more by using a physician that does not accept assignment.

Accepting Assignment

To avoid having to pay excess charges, always ask your physicians and medical suppliers whether they accept assignment. Some do on a case-by-case basis while others sign participation agreements with Medicare and accept the Medicare-approved amount as full payment on all Medicare claims. They are called participating physicians and suppliers and they are listed in *The Medicare Participating Physician/Supplier Directory*.

The directory is distributed to senior citizen organizations, all Social Security and Railroad Retirement Board offices, hospitals, and all state and area offices of the Administration on Aging. It also is available free by writing or calling the insurance company that processes Medicare Part B claims for your area. The names, addresses and telephone numbers of the companies, which are called Medicare "carriers," are listed in the back of *The Medicare Handbook*, available from any Social Security Administration office.

Besides avoiding excess charges, another advantage of using physicians or suppliers who accept assignment is that they are paid directly by Medicare, except for the deductible and coinsurance amounts that you must pay. Those who do not accept assignment collect the full amount of the bill from you. Medicare then reimburses you its share of the approved amount for the services or supplies received. Regardless of whether your physicians and suppliers accept assignment, they must file your Medicare claim for you.

In certain situations non-participating physicians and suppliers who do not normally accept assignment are required by law to do so. For instance, all physicians and qualified laboratories must accept assignment for clinical diagnostic laboratory tests covered by Medicare. Physicians also must accept assignment for covered services provided to beneficiaries with incomes low enough to qualify for Medicaid payment of their Medicare cost-sharing requirements (see page 23).

Physician Charge Limits

While physicians who do not accept assignment of a Medicare claim can charge more than physicians who do, there is a limit to the amount they can charge for services covered by Medicare. They are permitted to charge you only 15 percent more than the Medicare-approved amount, and you must pay that extra amount. This is called the "limiting charge" and you do not have to pay more than this amount.

To determine the limiting charge for a particular service, contact the Medicare carrier for your area. Limiting charge information also appears on the Explanation of Medicare Benefits (EOMB) form generally sent to you by the carrier after you receive a Medicare-covered service. If your physician has exceeded the charge limit, contact the physician and ask for a reduction in the charge, or a refund if you have paid the bill. If you cannot resolve the issue with the physician, call your Medicare carrier.

Under a new law all Medicare carriers are required to screen physician bills for overcharges and notify the physician and the patient within 30 days of any overcharge. The physician is then required to refund the overcharge within 30 days or credit your account for it. Physicians who knowingly, willfully and repeatedly charge more than the legal limit are subject to sanctions.

Some states have also enacted charge limit laws. Currently, Connecticut, Massachusetts, Minnesota, New York, Ohio, Pennsylvania, Rhode Island and Vermont have such laws. If you live in one of these states, or if you want to find out whether your state has a law limiting physician charges, contact your state insurance department counseling program or office on aging (see listings beginning on page 27).

Other Charge Limits

Physicians who do not accept assignment for elective surgery are required to give you a written estimate of your costs before the surgery if the total charge will be $500 or more. If you are not given a written estimate, you are entitled to a refund of any amount you paid in excess of the Medicare-approved amount. Additionally, any non-participating physician who provides you with services that he or she knows or has reason to believe Medicare will determine to be medically unnecessary, and thus will not pay for, is required to tell you that in writing before performing the service. If written notice is not given, and you did not know that Medicare would not pay, you cannot be held liable to pay for that service. However, if you did receive written notice and signed an agreement to pay for the service, you will be held liable to pay.

Gaps In Doctor and Medical Supplier Coverage

You Pay:

- $100 annual deductible.
- Generally, 20% coinsurance and permissible charges in excess of Medicare-approved amount.
- 50% of the Medicare-approved amounts for most outpatient mental health treatment.
- All charges in excess of Medicare's maximum yearly payment of $720 for independent physical or occupational therapists.
- All charges for most services that are not reasonable and necessary for the diagnosis or treatment of an illness or injury.
- All charges for most self-administerable prescription drugs and immunizations, except for pneumococcal, influenza and hepatitis B vaccinations.
- All charges for routine physicals and other screening services, except for mammograms and Pap smears.
- All charges for routine eye examinations or eyeglasses, except prosthetic lenses after cataract surgery.
- All charges for acupuncture treatment.
- All charges for most dental care and dentures.
- All charges for hearing aids or routine hearing loss examinations.
- All charges for care outside the United States and its territories, except in certain instances in Canada and Mexico.
- All charges for routine foot care except when a medical condition affecting the lower limbs (such as diabetes) requires care by a medical professional.
- All charges for services of naturopaths, Christian Science practitioners, immediate relatives, or charges imposed by members of your household.
- Unless replaced, all charges for the first 3 pints of whole blood or units of packed cells used in each year in connection with covered services. To the extent the 3-pint blood deductible is met under Part A, it does not have to be met under Part B.

Medicare Benefit Charts

The charts on pages 9 and 10 describe Medicare benefits only. The "You Pay" column itemizes expenses you are responsible for and must pay out of your own pocket or through the purchase of some type of private insurance as described in this booklet.

MEDICARE (PART A): HOSPITAL INSURANCE COVERED SERVICES FOR 1996

Services	Benefit	Medicare Pays	You Pay
HOSPITALIZATION Semiprivate room and board, general nursing and other hospital services and supplies. (Medicare payments based on benefit periods; see pg.3.)	First 60 days	All but $736	$736
	61st to 90th day	All but $184 a day	$184 a day
	91st to 150th day*	All but $368 a day	$368 a day
	Beyond 150 days	Nothing	All costs
SKILLED NURSING FACILITY CARE Semiprivate room and board, skilled nursing and rehabilitative services and other services and supplies. ** (Medicare coverage based on benefit periods; see pg. 3.)	First 20 days	100% of approved amount	Nothing
	Additional 80 days	All but $92 a day	Up to $92 a day
	Beyond 100 days	Nothing	All costs
HOME HEALTH CARE Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services.	Unlimited as long as you meet Medicare requirements for home health care benefits.	100% of approved amount; 80% of approved amount for durable medical equipment.	Nothing for services; 20% of approved amount for durable medical equipment.
HOSPICE CARE Pain relief, symptom management and support services for the terminally ill.	For as long as doctor certifies need.	All but limited costs for outpatient drugs and inpatient respite care.	Limited cost sharing for outpatient drugs and inpatient respite care.
BLOOD When furnished by a hospital or skilled nursing facility during a covered stay.	Unlimited during a benefit period if medically necessary.	All but first 3 pints per calendar year.	For first 3 pints.***

* 60 reserve days may be used only once.

** Neither Medicare nor Medigap insurance will pay for most nursing home care.

*** To the extent the three pints of blood are paid for or replaced under one part of Medicare during the calendar year, they do not have to be paid for or replaced under the other part.

MEDICARE (PART B): MEDICAL INSURANCE COVERED SERVICES FOR 1996

Services	Benefit	Medicare Pays	You Pay
MEDICAL EXPENSES Physician's services, inpatient and outpatient medical and surgical services and supplies, physical and speech therapy, diagnostic tests, durable medical equipment and other services.	Unlimited if medically necessary.	80% of approved amount (after $100 deductible). 50% of approved amount for most outpatient mental health services.	$100 deductible,* plus 20% of approved amount and limited charges above approved amount.** 50% for most mental health services.
CLINICAL LABORATORY SERVICES Blood tests, urinalysis, and more.	Unlimited if medically necessary.	Generally 100% of approved amount.	Nothing for services.
HOME HEALTH CARE Part-time or intermittent skilled care, home health aide services, durable medical equipment and supplies and other services.	Unlimited as long as you meet Medicare requirements.	100% of approved amount; 80% of amount Medicare approves for durable medical equipment.	Nothing for services; 20% of amount Medicare approves for durable medical equipment.
OUTPATIENT HOSPITAL TREATMENT Services for the diagnosis or treatment of an illness or injury.	Unlimited if medically necessary.	Medicare payment to hospital based on hospital costs.	20% of billed amount (after $100 deductible).*
BLOOD	Unlimited if medically necessary.	80% of approved amount (after $100 deductible and starting with 4th pint).	First 3 pints plus 20% of approved amount for additional pints (after $100 deductible). ***

* Once you have had $100 of expense for covered services, the Part B deductible does not apply to any other covered services you receive for the rest of the year.

** Federal law limits charges for physician services (see page 7).

*** To the extent any of the three pints of blood are paid for or replaced under one part of Medicare during the calendar year they do not have to be paid for or replaced under the other part.

TYPES OF PRIVATE HEALTH INSURANCE

If, after considering your various options, you decide that you need more insurance, there is a variety of private insurance policies available to help pay for medical expenses, services and supplies that Medicare covers only partially or not at all. The basic types of coverage include:

1. Medigap policies that pay some of the amounts that Medicare does not pay for covered services and which may pay for certain services not covered by Medicare;
2. Managed care plans such as health maintenance organizations (HMOs) from which you purchase health care services directly for a fixed monthly premium;
3. Continuation or conversion of an employer-provided or other policy you have when you reach 65;
4. Nursing home or long-term care policies, which pay cash amounts for each day of covered nursing home or at home care;
5. Hospital indemnity policies, which pay cash amounts for each day of inpatient hospital services; and,
6. Specified disease policies, which pay only when you need treatment for the insured disease.

Each of these alternatives will be discussed in turn, but let's start with Medigap insurance.

Medigap

Medigap insurance, which most beneficiaries buy because it is specifically designed to supplement Medicare's benefits, is regulated by federal and state law and must be clearly identified as Medicare supplement insurance. It provides specific benefits that help fill the gaps in your Medicare coverage. Other kinds of insurance may help you with out-of-pocket health care costs but they do not qualify as Medigap plans.

Standard Medigap Plans: To make it easier for consumers to comparison shop for Medigap insurance, nearly all states, U.S. territories and the District of Columbia limit the number of different Medigap policies that can be sold in any of those jurisdictions to no more than 10 standard Medigap plans. The plans, which are described beginning on page 12, were developed by the National Association of Insurance Commissioners and incorporated into state and federal law.

They have letter designations ranging from "A" through "J," with Plan A being the "basic" benefit package. Each of the other 9 plans includes the basic package plus a different combination of additional benefits. The plans cover specific expenses either not covered or not fully covered by Medicare, with "A" being the most basic policy and "J" the most comprehensive. Insurance companies are not permitted to change the combination of benefits or the letter designations of any of the plans.

Each state must allow the sale of Plan A and all Medigap insurers must make Plan A available if they are going to sell any Medigap plans in a state. While not required to offer any of the other 9 plans, most insurers offer several plans to pick from, and some offer all 10. They can independently decide which of the 9 optional plans they will sell as long as the plans they select have been approved for sale in the state in which they are to be sold. Some states have limited the number of plans available in the state. For example, Delaware does not permit the sale of Plans C, F, G and H and Vermont prohibits the sale of Plans F, G and I.

Residents of Minnesota, Massachusetts and Wisconsin will find that their Medigap plans are different from those sold in other states. This is because these states had alternative Medigap standardization programs in effect before the federal legislation standardizing Medigap was enacted. Therefore, these states were not required to change their Medigap plans. If you live in Minnesota, Massachusetts or Wisconsin, contact your state insurance department to find out what Medigap coverage is available.

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Standard Medigap Plans

Following is a list of the 10 standard plans and the benefits provided by each:

PLAN A (the basic policy) consists of these basic benefits:

- Coverage for the Part A coinsurance amount ($184 per day in 1996) for the 61st through the 90th day of hospitalization in each Medicare benefit period.
- Coverage for the Part A coinsurance amount ($368 per day in 1996) for each of Medicare's 60 non-renewable lifetime hospital inpatient reserve days used.
- After all Medicare hospital benefits are exhausted, coverage for 100% of the Medicare Part A eligible hospital expenses. Coverage is limited to a maximum of 365 days of additional inpatient hospital care during the policyholder's lifetime. This benefit is paid either at the rate Medicare pays hospitals under its Prospective Payment System (PPS) or under another appropriate standard of payment for hospitals not subject to the PPS.
- Coverage under Medicare Parts A and B for the reasonable cost of the first 3 pints of blood or equivalent quantities of packed red blood cells per calendar year unless replaced in accordance with federal regulations.
- Coverage for the coinsurance amount for Part B services (generally 20% of approved amount; 50% of approved charges for outpatient mental health services) after $100 annual deductible is met.

PLAN B includes the basic benefit plus:

- Coverage for the Medicare Part A inpatient hospital deductible ($736 per benefit period in 1996).

PLAN C includes the basic benefit plus:

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care coinsurance amount ($92 per day for days 21 through 100 per benefit period in 1996).
- Coverage for the Medicare Part B deductible ($100 per calendar year in 1996).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.

PLAN D includes the basic benefit plus:

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for at home recovery. The at home recovery benefit pays up to $1,600 per year for short-term, at home assistance with activities of daily living (bathing, dressing, personal hygiene, etc.) for those recovering from an illness, injury or surgery. There are various benefit requirements and limitations (see page15).

PLAN E includes the basic benefit plus:

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for preventive medical care. The preventive medical care benefit pays up to $120 per year for such things as a physical examination, serum cholesterol screening, hearing test, diabetes screenings, and thyroid function test.

PLAN F includes the basic benefit plus:

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for the Medicare Part B deductible.
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for 100% of Medicare Part B excess charges.*

PLAN G includes the basic benefit plus:

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for 80% of Medicare Part B excess charges.*
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for at home recovery (see Plan D).

PLAN H includes the basic benefit plus:

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for 50% of the cost of prescription drugs up to a maximum annual benefit of $1,250 after the policyholder meets a $250 per year deductible (this is called the "basic" prescription drug benefit).

PLAN I includes the basic benefit plus:

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for 100% of Medicare Part B excess charges.*
- Basic prescription drug coverage (see Plan H for description).
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for at home recovery (see Plan D).

PLAN J includes the basic benefit plus:

- Coverage for the Medicare Part A deductible.
- Coverage for the skilled nursing facility care daily coinsurance amount.
- Coverage for the Medicare Part B deductible.
- Coverage for 100% of Medicare Part B excess charges.*
- 80% coverage for medically necessary emergency care in a foreign country, after a $250 deductible.
- Coverage for preventive medical care (see Plan E).
- Coverage for at home recovery (see Plan D).
- Coverage for 50% of the cost of prescription drugs up to a maximum annual benefit of $3,000 after the policyholder meets a $250 per year deductible (this is called the "extended" drug benefit).

* Plan pays a specified percentage of the difference between Medicare's approved amount for Part B services and the actual charges (up to the amount of charge limitations set by either Medicare or state law).

Chart of the Ten Standard Medicare Supplement Plans

Medicare supplement insurance can be sold in only 10 standard plans. This chart shows the benefits included in each plan.
Every company must make available Plan A. Some plans may not be available in your state.

Basic Benefits: Included in All Plans.
Hospitalization: Part A coinsurance plus coverage for 365 additional days after Medicare benefits end.
Medical Expenses: Part B coinsurance (generally 20% of Medicare-approved expenses).
Blood: First 3 pints of blood each year.

A	B	C	D	E	F	G	H	I	J
Basic	Basic	Basic	Basic	Basic	Basic	Basic	Basic	Basic	Basic
		Skilled Nursing	Skilled Nursing	Skilled Nursing	Skilled Nursing	Skilled Nursing	Skilled Nursing	Skilled Nursing	Skilled Nursing
	Part A	Part A	Part A	Part A	Part A	Part A	Part A	Part A	Part A
		Part B			Part B				Part B
					Part B Excess	Part B Excess		Part B Excess	Part B Excess
		Foreign Travel	Foreign Travel	Foreign Travel	Foreign Travel	Foreign Travel	Foreign Travel	Foreign Travel	Foreign Travel
			At Home			At Home		At Home	At Home
							Basic Drug Benefit	Basic Drug Benefit	Extended Drug Benefit
				Preventive					Preventive

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The only areas where standardization is not in effect are Guam, American Samoa and the Commonwealth of the Northern Mariana Islands.

Innovative Benefits: Besides the standardized benefit plans, federal law permits states to allow an insurer to add "new and innovative benefits" to a standardized plan. Any such new or innovative benefits must be cost-effective, not otherwise available in the marketplace, and offered in a manner that is consistent with the goal of simplification. Check with your state insurance department to find out whether such benefits are available in your state.

Comparing Medigap Plans: Medigap insurers must use the same format, language and definitions in describing the benefits of each of the Medigap plans. They are also required to use a uniform chart and outline of coverage to summarize the benefits. As you shop for a Medigap policy, keep in mind that each company's products are alike, so they are competing on service, reliability and price. Compare benefits and premiums and be satisfied that the insurer is reputable before buying.

What Medigap Plans Cover: Medigap policies pay most, if not all, Medicare coinsurance amounts and may provide coverage for Medicare's deductibles. Some of the 10 standard plans pay for services not covered by Medicare such as outpatient prescription drugs, preventive screening, and emergency medical care while traveling outside the United States. Coverage is also provided in some plans for provider charges in excess of Medicare's approved amount and for at home personal care services.

Some of the benefits have dollar limits. For example, the at home recovery benefit available in some plans pays up to $40 per visit for up to seven visits a week and can be used up to 8 weeks after your Medicare-covered home health care visits stop. The maximum benefit is $1,600 per calendar year. To qualify for the at home recovery benefit, you must receive Medicare-covered home health care services after an illness, injury or surgery and the services covered by the Medigap policy must be ordered by your doctor.

Both the basic and the extended outpatient prescription drug benefits also have pay-out limits. Under basic coverage, you are responsible for a $250 deductible each calendar year, after which the policy covers 50 percent of outpatient prescription drug charges up to a maximum of $1,250 in benefits per calendar year. The extended prescription drug benefit also pays 50 percent of your drug bills up to a maximum of $3,000 per year after you pay the first $250.

The preventive screening benefit pays a maximum of $120 per year for physician-ordered health care screenings. The foreign travel emergency benefit covers 80 percent of the costs of emergency medical care begun during the first 2 months of each trip outside the United States after you pay the $250 annual deductible. There is a lifetime maximum benefit of $50,000.

Unlike some types of health coverage that restrict where and from whom you can receive care, Medigap policies generally pay the same supplemental benefits regardless of your choice of health care provider. If Medicare pays for a service, wherever provided, the standard Medigap policy must pay its regular share of benefits. The only exception is Medicare SELECT.

Medicare SELECT: Another Medicare supplement health insurance product called "Medicare SELECT," is permitted to be sold by insurance companies and HMOs throughout the country.

Medicare SELECT is the same as standard Medigap insurance in nearly all respects. If you buy a Medicare SELECT policy, you are buying one of the standard Medigap plans.

The only difference between Medicare SELECT and standard Medigap insurance is that each insurer has specific hospitals, and in some cases specific doctors, that you must use, except in an emergency, in order to be eligible for full benefits. Medicare SELECT policies generally have lower premiums in comparison to other Medigap policies because of this requirement.

When you go to the insurer's "preferred providers," Medicare pays its share of the approved charges and the insurer is responsible for the full supplemental benefits provided for in the policy. In general, Medicare SELECT policies are not required to pay any benefits if you do not use a preferred provider for non-emergency services. Medicare, however, will still pay its share of approved charges regardless of the provider you choose.

Congress designed Medicare SELECT as an experimental program and initially approved its availability in 15 states. Last year Congress expanded the program to include all states and extended it for another three years. Even if Congress decides not to continue Medicare SELECT, insurers will be required to honor all existing Medicare SELECT policies. If you have a Medicare SELECT policy and the program is terminated in 1998, you will be able to either keep the SELECT policy with no changes in benefits or, regardless of the status of your health, purchase another Medigap policy offered by the insurer, if the insurer issues Medigap insurance other than Medicare SELECT. To the extent possible, the replacement policy would have to provide similiar benefits.

While authorized for sale in every state, Medicare SELECT may not yet have been approved for sale in your state. You can find out whether it is available to you by calling your state insurance department or state insurance counseling office.

Medigap Premiums: Although the benefits are identical for all Medigap plans of the same type, the premiums may vary greatly from one company to another and from area to area. Insurance companies use three different methods to calculate premiums: issue age, attained age and no age rating.

If your company uses the issue age method, and you were 65 when you bought the policy, you will always pay the same premium the company charges people who are 65 regardless of your age. If it uses the attained age method, the premium is based on your current age and will increase as your grow older.

Under the no age rating, everyone pays the same premium regardless of age. Your state insurance department must approve the rates charged for all Medigap policies. The insurance company can raise your premiums only when it has approval to raise the premiums for everyone else with the same policy.

Open Enrollment Guarantees Your Right To Medigap Coverage: State and federal laws guarantee that for a period of 6 months from the date you are both enrolled in Medicare Part B and age 65 or older, you have a right to buy the Medigap policy of your choice regardless of any health problems you may have. If, however, your birthday falls on the first day of the month, your Part B coverage (if you buy it) begins on the first day of the previous month, while you are still 64. Your Medigap open enrollment period would also begin at that time.

During this 6-month open enrollment period, you can buy any Medigap policy sold by any insurer doing Medigap business in your state. The company cannot deny or condition the issuance or effectiveness, or discriminate in the pricing of a policy because of your medical history, health status or claims experience. The company can, however, impose the same preexisting condition restrictions (see pages 17 and 25) that it applies to Medigap policies sold outside the open enrollment period.

Your Medicare card shows the effective dates for your Part A and/or Part B coverage. To figure whether you are in your Medigap open enrollment period, add 6 months to the effective date of your Part B coverage. If the date is in the future and you are at least 65, you are eligible for open enrollment. If the date is in the past, you are generally not eligible. (If you were entitled to Medicare before age 65, see the following section on open enrollment and the disabled.)

If you are covered under an employer group health plan when you become eligible for Part B at age 65, carefully consider your options. Once you enroll in Part B, the 6-month Medigap open enrollment period starts and cannot be extended or repeated.

If you are covered under an employer plan that is primary to Medicare in paying your medical bills, you will not need a Medigap plan until you are no longer covered under the employer plan. If you begin buying Part B as a supplement to your employer plan while it is the primary payer, you will trigger your Medigap open enrollment period when it is of little use to you.

You may, therefore, want to wait to buy Part B until you are ready to make optimum use of your Medigap open enrollment period. Also keep in mind that if you have already triggered your Medigap open enrollment period at age 65, you cannot get another one by dropping Part B and reenrolling during a special enrollment period after you are no longer covered under the employer plan.

Medigap Open Enrollment and the Disabled: If you become eligible for Part B benefits before age 65 because of a disability or permanent kidney failure, federal law guarantees you access to the Medigap policy of your choice when you reach age 65.

During the first 6 months you are age 65 and enrolled in Part B, you can buy the policy of your choice regardless of whether you had enrolled in Part B before you were 65. Your Medigap 6-month open enrollment period begins on the first day of the month in which you turn 65, unless your birthday is on the first of the month, in which case it begins the first day of the preceding month.

During these 6 months, you cannot be refused a policy because of your disability or for other health reasons. Moreover, you cannot be charged more than other applicants, which can greatly reduce the amount you are paying. This includes Medigap policies that cover outpatient drugs, if they are available in your state. A waiting period of up to six months, however, may be imposed for coverage of a preexisting condition.

A few states go beyond federal law and require at least a limited open enrollment for Medicare Part B beneficiaries under 65. Check to see whether your state does. In addition to any state requirement, federal law requires that you be given an open enrollment opportunity when you turn 65, even if you were previously entitled to open enrollment under state law. The Medigap open enrollment period at age 65 for all disabled and kidney failure beneficiaries is a requirement that went into effect January 1, 1995.

Guaranteed Renewable: All standard Medigap policies are guaranteed renewable. This means that the insurance company cannot refuse to renew your policy unless you do not pay the premiums or you made material misrepresentations on the application. Older policies may allow the company to refuse to renew on an individual basis. These older policies provide the least permanent coverage.

Older Medigap Policies: Many federal requirements do not apply to Medigap policies sold before 1992, when Medigap was standardized. There is generally no requirement that you switch to one of the 10 standard plans if you have an older policy. However, you may be required to switch if your older plan was not guaranteed renewable and the company discontinues the type of policy you have.

Check with your state insurance department to find out what state-specific requirements are in force. Even if you are not required to convert an older policy, you may want to consider switching to one of the standardized Medigap plans if it is to your advantage and an insurer is willing to sell you one.

If you do switch, you will not be allowed to go back to the old policy. Before switching, compare benefits and premiums, and determine if there are waiting periods for any of the benefits in the new policy. Some of the older policies may provide better coverage, especially for prescription drugs and extended skilled nursing care.

You do not need more than one Medigap policy. If you already have a Medigap policy, you must sign a statement when you buy another indicating that you intend to replace your current policy and will not keep both policies. However, do not cancel the old policy until the new one is in force and you have decided to keep it.

Use the "Free-Look" Provision: Insurance companies must give you at least 30 days to review a Medigap policy. If you decide you don't want the policy, send it back to the agent or company within 30 days of receiving it and ask for a refund of all premiums you paid. Contact your state insurance department if you have a problem getting a refund.

If you have a Medigap policy at least 6 months and you decide to switch, the replacement policy cannot impose a waiting period for a preexisting condition. If, however, a benefit is included in the new policy that was not in the old policy, a waiting period of up to 6 months—unless prohibited by your state—may be applied to that particular benefit.

Non-Standard Plans: It is illegal for anyone to sell you a Medigap plan that does not conform to Medigap standardization requirements. This may include a "retainer agreement" that your doctor may offer you under which he or she will provide certain non-Medicare-covered services and waive the Medicare coinsurance and deductible amounts. This arrangement may violate federal laws governing Medigap policies.

If a doctor refuses to see you as a Medicare patient unless you pay him or her an annual fee and sign one of these retainer agreements, you should register a complaint with federal authorities by calling **1-800-638-6833**.

Carrier Filing of Medigap Claims: Under certain circumstances, when you receive medical services covered by both Medicare and your Medigap insurance, you may **not** have to file a separate claim with your Medigap insurer in order to have payment made directly to your physician or medical supplier.

By law, the Medicare carrier that processes Medicare claims for your area must send your claim to the Medigap insurer for payment when the following three conditions are met for a Medicare Part B claim:

1. Your physician or supplier must have signed a participation agreement with Medicare to accept assignment of Medicare claims for all patients who are Medicare beneficiaries;
2. Your policy must be a Medigap policy; and
3. You must instruct your physician to indicate on the Medicare claim form that you wish payment of Medigap benefits to be made to the participating physician or supplier. Your physician will put your Medigap policy number on the Medicare claim form.

When these conditions are met, the Medicare carrier will process the Medicare claim, send the claim to the Medigap insurer and generally send you an Explanation of Medicare Benefits (EOMB). Your Medigap insurer will pay benefits directly to your physician or medical supplier and send you a notice that it has done so.

If the insurer refuses to pay the physician directly when these three conditions are met, you should report this to your state insurance department. For more information on Medigap claim filing by the carrier, contact the Medicare carrier. Look in *The Medicare Handbook* for the name and telephone number of the carrier for your area.

Under another arrangement, some Medigap insurers have "crossover" contracts with Medicare. If your company has a crossover contract, Medicare will automatically send all of your claims directly to the insurer, even if the doctor has not signed a participation agreement with Medicare.

Managed Care Plans That Contract With Medicare

Managed care plans are sometimes called coordinated care or prepaid plans or HMOs. They might be thought of as a combination insurance company and doctor/hospital. Like an insurance company, they cover health care costs in return for a monthly premium, and like a doctor or hospital, they provide health care services.

Each plan has its own network of hospitals, skilled nursing facilities, home health agencies, doctors and other professionals. Depending on how the plan is organized, services are usually provided either at one or more centrally located health care facilities or in the private practice offices of the doctors and other health care professionals that are part of the plan.

Most managed care plans allow you to select a primary care doctor from those that are part of the plan. If you do not make a selection, one will be assigned to you. Your primary care doctor is responsible for managing your medical care, admitting you to a hospital and referring you to specialists.

You may have to pay a fixed montly premium to the plan and small copayments each time you go to the doctor or use other services. The premiums and copayments vary from plan to plan and can be changed each year. You also must continue to pay the Part B premium to Medicare. You do not pay Medicare's deductibles and coinsurance.

Usually there are no additional charges no matter how many times you visit the doctor, are hospitalized, or use other covered services. You will get all of the Medicare hospital and medical benefits to which you are entitled through the plan, and, as a plan member, you would retain all of your Medicare protections and appeal rights.

Before joining a plan, ask whether the plan has a "risk" or a "cost" contract with Medicare. Plans with risk contracts have "lock-in" requirements. This means that you generally are locked into receiving all covered care through the plan or through referrals by the plan.

In most cases, if you go outside t he plan for services, neither the plan nor Medicare will pay. You'll be responsible for the entire bill. The only exceptions recognized by all Medicare-contracting plans are for emergency services, which you may receive anywhere in the United States, and for urgently needed care, which you may receive while temporarily away from the plan's service area.

There is a third exception now offered by a few risk plans. It is called the "point-of-service" (POS) option. Under the POS option, the plan permits you to receive certain services outside the plan's established provider network and the plan will pay a percentage of the charges. In return for this flexibility, you must pay a portion of the cost. Expect to pay at least 20 percent of the bill.

Unlike risk plans, cost plans do not have lock-in requirements. If you enroll in a cost plan, you can either go to health care providers affiliated with the plan or go outside the plan. If you go outside the plan, the plan probably will not pay but Medicare will. Medicare will pay it's share of charges it approves.You will be responsible for Medicare's coinsurance, deductibles and other charges, just as if you were receiving care under the fee-for-service system. Because of this flexibility, a cost plan may be a good choice for you if you travel frequently, live in another state part of the year, or want to continue to use a physician who is not affiliated with a plan.

While benefits vary from plan to plan, all plans that have either a risk or cost contract must provide all of the Medicare benefits generally available in the plan's service area. Whether you are entitled to Parts A and B, or Part B only, you can get all of your Medicare benefits through the plan. In addition to offering you all your Medicare benefits, many plans promote preventive health care by providing extra benefits such as eye examinations, hearing aids, checkups, scheduled inoculations and prescription drugs for little or no extra fee.

Managed Care Plan Enrollment: Most Medicare beneficiaries are eligible for enrollment in a managed care plan with a risk or cost contract, and many parts of the country are served by one or more of these plans that have Medicare contracts. You are eligible to enroll if you live in the plan's service area, have Medicare Part B, do not have permanent kidney failure, and have not elected the Medicare hospice benefit. The plan must enroll Medicare beneficiaries, including younger disabled Medicare ben-

eficiaries, in the order of application, without health screening, during at least one 30-day open enrollment period each year.

You can find out which plans serve your area by calling any Social Security Administration office. The information is also available from your state insurance counseling office (see state-by-state listing beginning on page 27).

Before joining a plan, be sure to read the plan's membership materials carefully to learn your rights and the type and extent of your coverage. If you live in an area served by more than one plan, compare benefits, costs and other features to determine which plan meets your needs. Also, carefully consider the advantages and disadvantages of enrolling in a plan if you travel a lot or live part of the year in another state. While some plans provide coverage for a fixed period of time when you travel, others do not.

You can stay in a managed care plan as long as it has a Medicare contract or you can leave at any time to join another plan or return to fee-for-service Medicare. To end your enrollment, send a signed request to the plan or to your local Social Security Administration office or, if appropriate, the Railroad Retirement Board. You return to fee-for-service Medicare the first day of the next month. To change from one managed care plan to another, simply enroll in the other plan as long as it has a Medicare contract. You are automatically disenrolled from the first plan.

Should you enroll in a plan and later move out of the plan's service area, you will have to disenroll and either return to regular fee-for-service Medicare or enroll in a plan that serves your new location. Because each plan is different, your benefits and premiums probably will not be exactly the same if you enroll in another plan.

Managed Care Plans and Medigap: If you have a Medigap policy and decide to enroll in a managed care plan, you may either keep the policy or, if after deciding you like the plan, you may cancel it. You will generally not need a Medigap policy if you enroll in a Medicare managed care plan, and retaining it after you enroll means that you may be paying twice for the same coverage.

In fact, until recently, insurers would have been prohibited from selling you a policy because it would duplicate benefits you were getting through the plan. However, this is no longer true. Therefore, before you give up your Medigap policy or let a Medigap open enrollment period expire, you should take the following factors into account and also consider discussing your particular circumstances with your state insurance counseling office.

If you enroll in a plan with a risk contract, a Medigap policy will likely be of little or no value to you during the time you are enrolled. If you go outside the plan for Medicare-covered services, neither Medicare nor a Medigap policy will pay benefits. With respect to services not covered by Medicare, many of the same benefits that would be covered under a Medigap policy will likely be available through the plan, and the Medigap policy will not reimburse you for the plan's premiums and copayments. However, if you leave the plan, and do not enroll in another one, you may not be able to buy the Medigap policy of your choice, especially if you have a health problem.

If you enroll in a cost plan, it is advisable to get all services through the plan, since you may already be paying a premium and would probably incur only minimal copayments each time you used a service. However, if you expect to go outside the plan for a lot of services, a Medigap policy might cover the deductibles and coinsurance you will incur.

Group Insurance

There are two principal sources of group insurance: employers and voluntary associations.

Employer Group Insurance for Retirees. When they reach 65 many people still have private insurance through their or their spouse's current employer or union membership. If you have such coverage,

find out if it can be continued after retirement. Check the price and the benefits, including benefits for your spouse.

Group health insurance that is continued after retirement usually has the advantage of having no waiting periods or exclusions for preexisting conditions, and the coverage is usually based on group premium rates, which may be lower than the premium rates for individually purchased policies. One note of caution, however. If you have a spouse under 65 who was covered under the prior policy, make sure you know what effect your continued coverage will have on his or her insurance protection.

Retirement plans provided by employers or unions are not subject to the rules that apply to Medigap policies. These plans have their own rules and might not fill the gaps in Medicare. Furthermore, they might not pay your medical expenses during any period in which you were eligible for Medicare but did not sign up for it. If you are uncertain how your plan works in conjunction with Medicare, get a copy of the benefits booklet or call the plan's benefit office and ask for an explanation of how the plan pays when you have Medicare. While the policy may not provide the same benefits as a Medigap policy, it may offer other benefits such as prescription drug coverage and routine dental care.

Retiree Health Benefits and Medigap. Until recently, it was illegal for an insurer to sell you a Medigap policy if it would duplicate other benefits you had under another policy such as a retiree health plan. This is no longer true. You may now be sold a Medigap plan even if it duplicates your retiree health plan benefits, and the Medigap plan must pay full benefits even if the retiree plan also pays for the same service. Your retiree health plan may, however, contain a coordination of benefits clause. If it does, it will not pay duplicate benefits. You may want to consult your state insurance counseling program before purchasing a Medigap policy that would duplicate any of your retiree plan benefits.

Special Rules for Working People Age 65 or Over. If you are age 65 or over and you or your spouse works, Medicare may be the secondary payer to any group health plan (GHP) you have through an employer, if the employer has 20 or more employees. This means that the employer plan pays first on your hospital and medical bills. If the employer plan does not pay all of your expenses, Medicare may pay secondary benefits for Medicare-covered services to supplement the amount paid by the employer plan. This requirement applies to those who have employer group health plan coverage as an employee, employer, self-employed person, or a business associate of the employer.

Employers with 20 or more employees must also offer the same health benefits, under the same conditions, to employees age 65 or over and to their spouses who are 65 or over, that they offer to younger employees and spouses.

You may accept or reject coverage under the employer group health plan. If you accept the employer plan, it will be your primary payer. If you reject the plan, Medicare will be the primary payer for Medicare-covered health services that you receive. If you reject the employer plan, an employer cannot provide you with a plan that pays supplemental benefits for Medicare-covered services or subsidize such coverage. An employer may, however, offer a plan that pays for health care services not covered by Medicare, such as hearing aids, routine dental care and physical checkups.

Bear in mind that if you elect to have Medicare as your primary payer and you enroll in Medicare Part B, your 6-month Medigap open enrollment period will be triggered.

Special Rules for Certain Disabled Medicare Beneficiaries. Medicare is also secondary to large group health plan (LGHP) coverage for certain people under age 65 who are entitled to Medicare based on disability. In this instance an LGHP is a plan of, or contributed to by, an employer or employee organization that covers the employees of at least one employer with 100 or more employees. This requirement applies to those who have GHP coverage as an employee, employer, self-employed person, business associate of an employer, or a family member of any of these people. An LGHP must

not treat any of these people differently because they are disabled and have Medicare.

Special Rules for Medicare Beneficiaries with Permanent Kidney Failure. Medicare is the secondary payer to GHPs for 18 months for beneficiaries who have Medicare because of permanent kidney failure. This requirement applies only to those with permanent kidney failure, whether they have their own coverage under a GHP or are covered under a GHP as dependents. GHPs are primary payers during this period without regard to the size of the GHP, the number of employees, or whether the individual works.

The 18-month period begins with the earlier of:

- The first month in which the person becomes entitled to Medicare Part A based on permanent kidney failure; or
- The first month in which an individual would have been entitled to Part A if he had filed an application for Medicare benefits.

However, GHPs may be primary for an additional 3 months, or a total of up to 21 months: the first 3 months of dialysis (a period during which an individual generally is not eligible for Medicare benefits) plus the first 18 months of Medicare eligibility or entitlement. After the period of up to 21 months expires, Medicare is the primary payer for entitled individuals and the GHP is secondary.

The Health Care Financing Administration pamphlet entitled *Medicare Coverage of Kidney Dialysis and Kidney Transplant Services* contains more information about Medicare and kidney disease. You can get a free copy from the Social Security Administration or the Consumer Information Center, Department 59, Pueblo, CO 81009.

Association Group Insurance. Many organizations, other than employers, offer group health insurance coverage to their members. Just because you are buying through a group does not mean that you are getting a low rate. Group insurance can be as expensive as or more costly than comparable coverage under individual policies. Be sure you understand the benefits included and then compare prices. Association group Medigap insurance must comply with the same rules that apply to other Medigap policies.

The following types of coverage are generally limited in scope and are not substitutes for Medigap insurance or managed care plans. Benefits under these policies are not designed to fill gaps in Medicare coverage.

Long-Term Care Insurance

Nursing home and long-term care insurance are available to cover custodial care in a nursing home. Some of these policies also cover at home care, and others are available to pay for care in a skilled nursing facility (SNF) even if Medicare benefits are unavailable (see page 4 for an explanation of the Medicare benefit for skilled nursing facility care). If you are in the market for nursing home or long-term care insurance, be sure you know which types of nursing homes and services are covered by the different policies available. And if you buy a policy, make sure it either does not duplicate skilled nursing facility coverage provided by any Medigap policy, managed care plan, or other coverage you have, or pays benefits without respect to that other coverage.

It is important to remember that purely custodial care (the type of care most persons in nursing homes require) is not covered by Medicare or most Medigap policies. The only nursing home care that Medicare covers is skilled nursing care or skilled rehabilitation care that is provided in a Medicare-certified skilled nursing facility.

For more information about long-term care insurance, request a copy of *A Shopper's Guide to Long-Term Care Insurance* from either your state insurance department or the National Association of Insurance Commissioners, 120 W. 12th Street, Suite 1100, Kansas City, MO 64105-1925. You may also obtain a copy of the *Guide to Choosing a Nursing Home* by writing to Medicare Publications, Health Care Financing Administration, 6325 Security Boulevard, Baltimore, MD 21207.

Hospital Indemnity Insurance

Hospital indemnity coverage is insurance that pays a fixed cash amount for each day you are hospitalized up to a designated number of days. Some coverage may have added benefits such as surgical benefits or skilled nursing home confinement benefits. Some policies have a maximum number of days or a maximum payment amount.

Specified Disease Insurance

Specified disease insurance, which is not available in some states, provides benefits for only a single disease, such as cancer, or for a group of specified diseases. The value of such coverage depends on the chance you will get the specific disease or diseases covered. Benefits are usually limited to payment of a fixed amount for each type of treatment. Remember, Medicare and any Medigap policy you have will very likely cover costs associated with any of these specified diseases you may contract.

DO YOU NEED MORE INSURANCE?

Whether you need health insurance in addition to Medicare is a decision that only you can make. As you saw from the review of Medicare benefits, Medicare does not offer complete health insurance protection. Private health insurance can fill many of the gaps. But before buying insurance to supplement your Medicare benefits, make sure you need it. Not everyone does.

Medicaid Recipients

If you are eligible for full Medicaid benefits, you may not need more insurance. Medicaid is a joint federal and state program that provides medical assistance for certain individuals with low incomes and limited assets. While coverage and eligibility vary from state to state, most of your health care costs would be covered if you qualified for both Medicare and Medicaid. In addition to standard hospital and medical coverage, states provide Medicaid recipients with benefits such as nursing home care and outpatient prescription drugs.

Besides the standard Medicaid program, there are two other programs available through state Medicaid offices that are designed specifically to help certain low-income Medicare beneficiaries meet their health care costs. One is called the "Qualified Medicare Beneficiary" (QMB) program and the other is called the "Specified Low-Income Medicare Beneficiary" (SLMB) program. While they do not necessarily eliminate the need for private insurance to supplement your Medicare benefits, they could save you hundreds of dollars each year in health care costs if you qualify for assistance.

QMB: The QMB program pays all of Medicare's premiums, deductibles and coinsurance amounts for certain elderly and disabled persons who are entitled to Medicare Part A, whose annual income is at or below the national poverty level, and whose savings and other resources are very limited. The QMB program, thus, functions like a Medigap policy and more because it also pays your Part B premium.

The QMB monthly income limits in 1996 are:

All states except Alaska and Hawaii
$665 (individual) $884 (couple)
Alaska: $825 (individual) $1,099 (couple)
Hawaii: $763 (individual) $1,014 (couple)

In addition to the income limit, financial resources such as bank accounts, stocks and bonds cannot exceed $4,000 for one person or $6,000 for a couple.

SLMB: The SLMB program is for persons entitled to Medicare Part A whose incomes are slightly higher than the national poverty level. Your income cannot exceed the national poverty level by more than 20 percent.

The SLMB monthly income limits in 1996 are:

All states except Alaska and Hawaii
$794 (individual) $1,057 (couple)
Alaska: $986 (individual) $1,314 (couple)
Hawaii: $912 (individual) $1,213 (couple)

If you qualify for assistance under the SLMB program, the state will pay your Medicare Part B premium. You will be responsible for Medicare's deductibles, coinsurance and other related charges.

Contact your state or local Medicaid or social service office if you think you qualify for full Medicaid benefits, or for either the QMB or SLMB program. If you cannot find the number in the telephone directory, call **1-800-638-6833** for assistance.

Medicaid And Medigap Plans: If you are entitled to both Medicare and regular Medicaid benefits, an insurance company cannot sell you a Medigap policy unless the state pays the premiums for you. If you qualify for QMB assistance, an insurer may not sell you a Medigap policy unless it includes coverage for prescription drugs. If you qualify for the SLMB program, there are no special restrictions on selling you a Medigap policy other than the restrictions that apply to all Medigap sales. In particular, an insurance company is prohibited from selling you a second Medigap policy unless you have stated in writing that you will terminate your existing policy.

If you should become eligible for any Medicaid benefits and have a Medigap policy purchased after November 4, 1991, you can suspend the Medigap premiums and benefits for up to two years while you are covered by Medicaid. Here's what you do:

- ☑ Notify your Medigap insurer within 90 days of becoming eligible for Medicaid. Both premiums and benefits will be suspended as of the date of notification.
- ☑ To resume coverage, ask the insurance company to reinstate the policy within 90 days of losing your Medicaid eligibility and begin paying premiums again. The policy must be reinstated as of the date on which you lost Medicaid eligibility.

You do not have to suspend your policy if you become eligible for Medicaid. Before you do it, discuss your options with your state Medicaid office.

Medicaid and Other Private Health Insurance: Medicaid will not pay if you have other insurance that will pay for benefits Medicaid would otherwise cover for you. Therefore, if you are considering buying a health insurance policy, you should check with the state Medicaid agency about how it would affect your Medicaid benefits, and with the state insurance counseling office about whether you will really benefit from having the policy.

Federally Qualified Health Center: Another way to limit your health care costs is to go to a federally qualified health center (FQHC) for the type of care generally provided in a doctor's office. Medicare pays for some health services that are not otherwise Medicare-covered services, such as preventive care services, when they are provided by an FQHC. These facilities are typically community health centers, Indian health clinics, migrant health centers and health centers for the homeless. They are generally located in inner-city and rural areas. The services covered by Medicare include:

- ☑ Routine physical examinations
- ☑ Screening and diagnostic tests for the detection of vision and hearing problems, as well as other medical conditions
- ☑ Administration of certain vaccines for immunization against influenza and other diseases.

When these services are furnished at an FQHC, the $100 annual Part B deductible does not apply. However, if other services are provided, such as X-rays or screening mammograms, the FQHC may bill the Medicare carrier. In that case, you would be responsible for any unmet portion of the Part B annual deductible of $100.

While the Part B 20 percent coinsurance applies to all FQHC services, Public Health Service guidelines allow FQHCs to waive it in some instances. Any Medicare beneficiary may go to an FQHC for health care services. To find out whether one of these centers serves your area, call **1-800-638-6833.**

TIPS ON SHOPPING FOR HEALTH INSURANCE

As was stated previously, whether you need health insurance in addition to Medicare is a decision that only you can make. If you decide to buy supplemental insurance, shop carefully and buy a policy that offers the kind of additional help you think you need most. Here are some helpful tips for you to keep in mind when shopping for health insurance.

Shop Carefully Before You Buy. Policies differ as to coverage and cost, and companies differ as to

service. Contact different companies and compare the premiums before you buy.

Don't Buy More Policies Than You Need. Duplicate coverage can be expensive and generally is unnecessary. A single comprehensive policy is better than several policies with overlapping or duplicate coverage. Federal law prohibits an insurer from selling you a second Medigap policy unless you state in writing that you intend to cancel the first policy after the replacement policy goes into effect. Recent changes in the law affect beneficiaries who get help from the state through its Medicaid program in paying their health care costs (see page 23 for details). Anyone who sells you a policy in violation of the various anti-duplication provisions is subject to criminal and/or civil penalties under federal law. Call **1-800-638-6833** to report suspected violations.

Consider Your Alternatives. Depending on your health care needs and finances, you may want to consider continuing the group coverage you have at work, joining a managed care plan, buying a Medigap policy, or buying a long-term care insurance policy.

Check For Preexisting Condition Exclusions. In evaluating a policy, you should determine whether it limits or excludes coverage for existing health conditions. Many policies do not cover health problems that you have at the time of purchase. Preexisting conditions are generally health problems you went to see a physician about within the 6 months before the date the policy went into effect.

If you have had a health problem, the insurer might not cover you for expenses connected with that problem. Medigap policies, however, are required to cover preexisting conditions after the policy has been in effect for 6 months. Some companies have shorter waiting periods before covering a preexisting condition.

Beware of Replacing Existing Coverage. Be careful when buying a replacement Medigap policy. Make sure you have a good reason for switching from one policy to another—you should only switch for different benefits, better service, or a more affordable price. On the other hand, don't keep inadequate policies simply because you have had them for a long time. If you decide to replace your Medigap policy, you must be given credit for the time spent under the old policy in determining whether and to what extent any preexisting conditions restrictions apply under the new policy. You must also sign a statement that you intend to terminate the policy to be replaced. Do not cancel the first policy until you are sure that you want to keep the new policy. You have 30 days to decide.

Policy Delivery or Refunds Should be Prompt. The insurance company should deliver a policy within 30 days. If it does not, contact the company and obtain in writing the reason for the delay. If 60 days go by without a response, contact your state insurance department.

Prohibited Marketing Practices. It is unlawful for a company or agent to use high pressure tactics to force or frighten you into buying a Medigap policy, or to make fraudulent or misleading comparisons to get you to switch from one company or policy to another. Deceptive "cold lead" advertising also is prohibited. This tactic involves mailings to identify individuals who might be interested in buying insurance. If you fill in and return the card enclosed in the mailing, the card may be sold to an insurance agent who will try to sell you a policy.

Be Aware of Maximum Benefits. Most policies have some type of limit on benefits. They may restrict either the dollar amount that will be paid for treatment of a condition or the number of days of care for which payment will be made. Some insurance policies (but not Medigap policies) pay less than the Medicare-approved amounts for hospital outpatient medical services and for services provided in a doctor's office. Others do not pay anything toward the cost of those services.

Be Aware That Policies to Supplement Medicare Are Neither Sold Nor Serviced by the State or Federal Governments. State insurance departments approve policies sold by private insurance companies but approval only means the company and policy meets requirements of state law. Do not believe statements that insurance to supplement Medi-

care is a government-sponsored program. If anyone tells you that they are from the government and later tries to sell you an insurance policy, report that person to your state insurance department or federal authorities. This type of misrepresentation is a violation of federal and state law. It is also unlawful for a company or agent to claim that a policy has been approved for sale in any state in which it has not received state approval, or to use fraudulent means to gain approval.

Know With Whom You're Dealing. A company must meet certain qualifications to do business in your state. You should check with your state insurance department to make sure that any company you are considering is licensed in your state. This is for your protection. Agents also must be licensed by your state and may be required by the state to carry proof of licensure showing their name and the company they represent. If the agent cannot verify that he or she is licensed, do not buy from that person. A business card is not a license.

Keep Agents' and/or Companies' Names, Addresses and Telephone Numbers. Write down the agents' and/or companies' names, addresses and telephone numbers or ask for a business card that provides all that information.

Take Your Time. Do not be pressured into buying a policy. Principled sales people will not rush you. If you are not certain whether a policy is what you need, ask the salesperson to explain it to a friend. Keep in mind, however, that there is a limited time period in which new Medicare Part B enrollees can buy the Medigap policy of their choice without special conditions being imposed (see page 16). Once this open enrollment period ends, you may be limited as to the Medigap policies available to you, especially if you have a preexisting health condition.

If You Decide To Buy, Complete the Application Carefully. Do not believe an insurance agent who says your medical history on an application is not important. Some companies ask for detailed medical information. If you leave out any of the medical information requested, coverage could be refused for a period of time for any medical condition you neglected to mention. The company also could deny a claim for treatment of an undisclosed condition and/or cancel your policy.

Look For an Outline of Coverage. You must be given a clearly worded summary of the policy . . . READ IT CAREFULLY.

Do Not Pay Cash. Pay by check, money order or bank draft made payable to the insurance company, not to the agent or anyone else. Get a receipt with the insurance company's name, address and telephone number for your records.

For Your Protection

As previously noted, federal criminal and civil penalties can be imposed against anyone who sells a Medigap or other health insurance policy in violation of the anti-duplication and other insurance laws. Penalties may also be imposed for claiming that a Medigap policy meets legal standards for federal certification when it does not, or for using the mail for the delivery of advertisements offering for sale a Medigap policy in a state in which it has not received approval.

Additionally, it is illegal under federal law for an individual or company to misuse the names, letters, symbols or emblems of the U.S. Department of Health and Human Services (DHHS), the Social Security Administration, or the Health Care Financing Administration. It also is illegal to use the names, letters, symbols or emblems of their various programs.

This law is aimed primarily at mass marketers that use this information on mail solicitations to imply that the product is either endorsed or is being sold by the U.S. government. The advertising literature is often designed to look like it came from a government agency. If you believe that you have been the victim of any unlawful insurance sales practices, contact your state insurance department immediately. If you believe that federal law has been violated, you may call **1-800-638-6833.** In most cases, however, your state insurance department can offer the most assistance in resolving insurance-related problems.

Directory of State Insurance Departments and Agencies on Aging

Each state has its own laws and regulations governing all types of insurance. The insurance offices, listed in the left column, are responsible for enforcing those laws as well as providing the public with information about insurance. The agencies on aging, listed in the right column, are responsible for coordinating services for older persons. The middle column of the directory lists the telephone number to call for insurance counseling services. Calls to an 800 number listed in this directory are free when made within the respective state.

Insurance Departments	Insurance Counseling	Agencies on Aging
Insurance Department Consumer Service Division 135 South Union St. P.O. Box 303351 Montgomery, AL 36130-3351 (334) 269-3550	**Alabama** 1-800-243-5463	Commission on Aging 770 Washington Ave., Suite 470 P.O. Box 301851 Montgomery, AL 36130 1-800-243-5463 (334) 242-5743
Division of Insurance 3601 "C" St., Suite 1324 Anchorage, AK 99503 (907) 269-7900	**Alaska** 1-800-478-6065 (907) 562-7249	Division of Senior Services 3601 "C" St., Suite 310 Anchorage, AK 99503 (907) 465-3250
Insurance Department Office of the Governor Pago Pago, AS 96799 011-684/633-4116	**American Samoa**	Territorial Admin. on Aging Government of American Samoa Pago Pago, AS 96799 (684) 633-1252
Insurance Department Consumer Affairs Division 2910 N. 44th St. Phoenix, AZ 85018 (602) 912-8444	**Arizona** 1-800-432-4040 (602) 542-6595	Dept. of Economic Security Aging & Adult Administration 1789 W. Jefferson St. Phoenix, AZ 85007 (602) 542-4446
Insurance Department Seniors Insurance Network 1123 S. University Avenue Suite 400 Little Rock, AR 72204 1-800-852-5494	**Arkansas** 1-800-852-5494 (501) 686-2940	Division of Aging and Adult Services 1417 Donaghey Plaza South P.O. Box 1437/Slot 1412 Little Rock, AR 72203-1437 (501) 682-2441
Insurance Department Consumer Services Div. 300 Capitol Mall Sacramento, CA 95814 (916) 445-5544	**California** 1-800-434-0222 (916) 323-7315	Department of Aging Health Insurance Counseling and Advocacy Branch 1600 K Street Sacramento, CA 95814 (916) 323-7315

Insurance Departments	Insurance Counseling	Agencies on Aging
Insurance Division 1560 Broadway Suite 850 Denver, CO 80202 (303) 894-7499, ext. 356	**Colorado** 1-800-544-9181 (303) 894-7499, ext. 356	Aging and Adult Services Dept. of Social Services 1575 Sherman St., 4th Fl. Denver, CO 80203-1714 (303) 866-3851
-	**Commonwealth of the Northern Mariana Islands**	Department of Community and Cultural Affairs Civic Center Commonwealth of the Northern Mariana Islands Saipan, CM 96950 (607) 234-6011
Insurance Department P.O. Box 816 Hartford, CT 06142-0816 (203) 297-3800	**Connecticut** 1-800-994-9422	Department of Social Services Elderly Services Division 25 Sigourney Street Hartford, CT 06106-5033 1-800-994-9422
Insurance Department Rodney Building 841 Silver Lake Blvd. Dover, DE 19904 1-800-282-8611 (302) 739-4251	**Delaware** 1-800-336-9500	Division of Aging Dept. of Health & Social Services 1901 N. DuPont Highway 2nd Fl. Annex Admin. Bldg. New Castle, DE 19720 (302) 577-4791
Insurance Department Consumer & Professional Services Bureau 441 4th Street, NW Suite 850 North Washington, D.C. 20001 (202) 727-8000	**District of Columbia** (202) 676-3900	Office on Aging 441 4th Street, NW 9th Floor Washington, D.C. 20001 (202) 724-5626 (202) 724-5622
	Federated States of Micronesia	State Agency on Aging Office of Health Services Federated States of Micronesia Ponape, E.C.I. 96941
Department of Insurance 200 E. Gaines Street Tallahassee, FL 32399-0300 (904) 922-3100	**Florida** 1-800-963-5337	Department of Elder Affairs 4040 Esplanade Way Suite 260 Tallahassee, FL 32399-7000 (904) 414-2060

Insurance Departments	Insurance Counseling	Agencies on Aging
Insurance Department 2 Martin L. King, Jr., Dr. 716 West Tower Atlanta, GA 30334 (404) 656-2056	**Georgia** 1-800-669-8387	Division of Aging Services Dept. of Human Resources 2 Peachtree St., NW, Rm 18.403 Atlanta, GA 30303 (404) 657-5258
Insurance Division Department of Revenue & Taxation P.O. Box 23607 GMF Barrigada Guam 96921 011 (671) 475-5000	**Guam** (671) 475-0262/3	Division of Senior Citizens Dept. of Public Health and Social Services P.O. Box 2816 Agana, Guam 96910 011 (671) 475-0262/3
Dept. of Commerce and Consumer Affairs Insurance Division P.O. Box 3614 Honolulu, HI 96811 (808) 586-2790	**Hawaii** (808) 586-0100	Executive Office on Aging 335 Merchant Street Room 241 Honolulu, HI 96813 (808) 586-0100
Insurance Department SHIBA Program 700 W. State St., 3rd Fl. Boise, ID 83720-0043 (208) 334-4350	**Idaho** S.W. - 1-800-247-4422 N. - 1-800-488-5725 S.E. - 1-800-488-5764 C. - 1-800-488-5731	Office on Aging Statehouse, Room 108 Boise, ID 83720 (208) 334-3833
Insurance Department 320 W. Washington St. 4th Floor Springfield, IL 62767 (217) 782-4515	**Illinois** 1-800-548-9034	Department on Aging 421 E. Capitol Ave., No. 100 Springfield, IL 62701-1789 1-800-252-8966
Insurance Department 311 W. Washington St. Suite 300 Indianapolis, IN 46204 1-800-622-4461 (317) 232-2395	**Indiana** 1-800-452-4800	Div. of Aging & Home Services 402 W. Washington St. P.O. Box 7083 Indianapolis, IN 46207-7083 1-800-545-7763 (317) 232-7020
Insurance Division Lucas State Office Bldg. E. 12th & Grand Sts. 6th Floor Des Moines, IA 50319 (515) 281-5705	**Iowa** 1-800-351-4664	Dept. of Elder Affairs 200 10th Street Third Floor Des Moines, IA 50309-3709 (515) 281-5187

Insurance Departments	Insurance Counseling	Agencies on Aging
Insurance Department 420 S.W. 9th Street Topeka, KS 66612 1-800-432-2484 (913) 296-3071	**Kansas** 1-800-432-3535	Department on Aging 150-S. Docking State Office Building 915 S.W. Harrison Topeka, KS 66612-1500 (913) 296-4986
Insurance Department 215 W. Main Street P.O. Box 517 Frankfort, KY 40602 (502) 564-3630	**Kentucky** 1-800-372-2973	Division of Aging Services Cabinet for Human Resources 275 E. Main St., 5th Floor, West Frankfort, KY 40621 (502) 564-6930
Department of Insurance P.O. Box 94214 Baton Rouge, LA 70804-9214 1-800-259-5301 (504) 342-5301	**Louisiana** 1-800-259-5301 (504) 342-5301	Governor's Office of Elderly Affairs 4550 N. Boulevard P.O. Box 80374 Baton Rouge, LA 70896-0374 (504) 925-1700
Bureau of Insurance 34 State House Station Augusta, ME 04333 (207) 624-8475	**Maine** 1-800-750-5353 (207) 624-5335	Bureau of Elder and Adult Services State House, Station 11 Augusta, ME 04333 (207) 624-5335
Insurance Administration Complaints and Investigation Unit - Life & Health 501 St. Paul Place Baltimore, MD 21202-2272 (410) 333-2793 (410) 333-2770	**Maryland** 1-800-243-3425	Office on Aging 301 W. Preston Street Room 1007 Baltimore, MD 21201 (410) 225-1100
Insurance Division Consumer Services Section 470 Atlantic Ave. Boston, MA 02210-2223 (617) 521-7777	**Massachusetts** 1-800-882-2003 (617) 727-7750	Executive Office of Elder Affairs 1 Ashburton Place, 5th Floor Boston, MA 02108 1-800-882-2003 (617) 727-7750
Insurance Bureau P.O. Box 30220 Lansing, MI 48909 (517)373-0240 (General Assistance) (517) 335-1702 (Senior Issues)	**Michigan** 1-800-803-7174 (517) 373-8230	Office of Services to the Aging 611 W. Ottawa Street P.O. Box 30026 Lansing, MI 48909 (517) 373-8230

Insurance Departments	Insurance Counseling	Agencies on Aging
Insurance Department Department of Commerce 133 E. 7th Street St. Paul, MN 55101-2362 (612) 296-4026	**Minnesota** 1-800-882-6262	Board on Aging Human Services Building 4th Floor 444 Lafayette Road St. Paul, MN 55155-3843 (612) 296-2770
Insurance Department Consumer Assistance Division P.O. Box 79 Jackson, MS 39205 (601) 359-3569	**Mississippi** 1-800-948-3090	Div. of Aging & Adult Services 750 N. State Street Jackson, MS 39202 1-800-948-3090 (601) 359-4929
Department of Insurance Consumer Services Section P.O. Box 690 Jefferson City, MO 65102-0690 1-800-726-7390 (314) 751-2640	**Missouri** 1-800-390-3330	Division of Aging Dept. of Social Services P.O. Box 1337 615 Howerton Court Jefferson City, MO 65102-1337 (314) 751-3082
Insurance Department 126 N. Sanders Mitchell Bldg., Rm. 270 P.O. Box 4009 Helena, MT 59601 (406) 444-2040	**Montana** 1-800-332-2272	Office on Aging/DPHHS 48 N. Last Chance Gulch P.O. Box 8005 Helena, MT 59604-8005 1-800-332-2272 (406) 444-7784
Insurance Department Terminal Building 941 "O" St., Suite 400 Lincoln, NE 68508 (402) 471-2201	**Nebraska** (402) 471-2201	Department on Aging State Office Building 301 Centennial Mall South Lincoln, NE 68509-5044 (402) 471-2306
Department of Business & Industry Division of Insurance 1665 Hot Springs Rd., Ste. 152 Carson City, NV 89710 1-800-992-0900 (702) 687-4270	**Nevada** 1-800-307-4444 (702) 367-1218	Dept. of Human Resources Division for Aging Services 340 N. 11th St., Suite 114 Las Vegas, NV 89101 (702) 486-3545
Insurance Department Life and Health Division 169 Manchester St. Concord, NH 03301 1-800-852-3416 (603) 271-2261	**New Hampshire** 1-800-852-3388 (603) 271-4642	Dept. of Health & Human Services Div. of Elderly & Adult Services State Office Park South 115 Pleasant Street Annex Building No. 1 Concord, NH 03301 (603) 271-4680

Insurance Departments	Insurance Counseling	Agencies on Aging
Insurance Department 20 West State Street Roebling Building CN 325 Trenton, NJ 08625 (609) 292-5363	**New Jersey** 1-800-792-8820	Dept. of Community Affairs Division on Aging 101 S. Broad Street CN 807 Trenton, NJ 08625-0807 1-800-792-8820 (609) 984-3951
Insurance Department P.O. Drawer 1269 Santa Fe, NM 87504-1269 (505) 827-4601	**New Mexico** 1-800-432-2080	State Agency on Aging La Villa Rivera Bldg. 224 E. Palace Ave. Santa Fe, NM 87501 1-800-432-2080 (505) 827-7640
Insurance Department 160 West Broadway New York, NY 10013 (212) 602-0203 Outside of New York City 1-800-342-3736	**New York** 1-800-333-4114 (212) 869-3850 - NY City area	State Office for the Aging 2 Empire State Plaza Albany, NY 12223-0001 1-800-342-9871 (518) 474-5731
Insurance Department Seniors' Health Insurance Information Program (SHIIP) P.O. Box 26387 Raleigh, NC 27611 1-800-662-7777 (Consumer Services) (919) 733-0111 (SHIIP)	**North Carolina** 1-800-443-9354	Division of Aging 693 Palmer Drive Caller Box 29531 Raleigh, NC 27626-0531 (919) 733-3983
Insurance Department Senior Health Ins. Counseling 600 E. Boulevard Bismarck, ND 58505-0320 1-800-247-0560 (701) 328-2440	**North Dakota** 1-800-247-0560	Dept. of Human Services Aging Services Division P.O. Box 7070 Bismarck, ND 58507-7070 1-800-755-8521 (701) 328-2577
Insurance Department Consumer Services Division 2100 Stella Court Columbus, OH 43215-1067 1-800-686-1526 (614) 644-2673	**Ohio** 1-800-686-1578	Department of Aging 50 W. Broad Street 9th Floor Columbus, OH 43215-5928 1-800-282-1206 (614) 466-1221

Insurance Departments	Insurance Counseling	Agencies on Aging
	Oklahoma 1-800-763-2828 (405) 521-6628	
Insurance Department P.O. Box 53408 Oklahoma City, OK 73152 1-800-522-0071 (405) 521-2828		Dept. of Human Services Aging Services Division 312 NE 28th Street Oklahoma City, OK 73125 (405) 521-2327
	Oregon 1-800-722-4134	
Dept. of Consumer & Business Services Senior Health Insurance Benefits Assistance 350 Winter St.,NE, Rm. 440 Salem, OR 97310 1-800-722-4134 (503) 378-4484		Dept. of Human Resources Senior & Disabled Services Division 500 Summer St., NE, 2nd Floor Salem, OR 97310-1015 1-800-232-3020 (503) 945-5811
	Palau	
		State Agency on Aging Dept. of Social Services Republic of Palau Koror, Palau 96940
	Pennsylvania 1-800-783-7067	
Insurance Department Consumer Services Bureau 1321 Strawberry Square Harrisburg, PA 17120 (717) 787-2317		Department of Aging "Apprise" Health Insurance Counseling and Assistance 400 Market Street Rachel Carson State Ofc. Bldg. Harrisburg, PA 17101 1-800-783-7067
	Puerto Rico (809) 721-5710	
Office of the Commissioner of Insurance P.O. Box 8330 San Juan, PR 00910-8330 (809) 722-8686		Governor's Office of Elderly Affairs Gericulture Commission Box 11398 Santurce, PR 00910 (809) 722-2429
	Republic of the Marshall Islands	
		State Agency on Aging Dept. of Social Services Republic of the Marshall Islands Marjuro, Marshall Islands 96960
	Rhode Island 1-800-322-2880	
Insurance Division 233 Richmond St., Suite 233 Providence, RI 02903-4233 (401) 277-2223		Dept. of Elderly Affairs 160 Pine Street Providence, RI 02903 (401) 277-2858

Insurance Departments	Insurance Counseling	Agencies on Aging
	South Carolina 1-800-868-9095	
Department of Insurance Consumer Services Section P.O. Box 100105 Columbia, SC 29202-3105 1-800-768-3467 (803) 737-6180		Division on Aging 202 Arbor Lake Drive Suite 301 Columbia, SC 29223-4554 (803) 737-7500
	South Dakota 1-800-354-8238 (605) 773-3656	
Insurance Department 500 E. Capitol Avenue Pierre, SD 57501-5070 (605) 773-3563		Office of Adult Services and Aging 700 Governors Drive Pierre, SD 57501-2291 (605) 773-3656
	Tennessee 1-800-525-2816	
Dept. of Commerce & Insurance Insurance Assistance Office 4th Floor 500 James Robertson Pkwy. Nashville, TN 37243 1-800-525-2816 (615) 741-4955		Commission on Aging Andrew Jackson Bldg., 9th Floor 500 Deaderick Street Nashville, TN 37243 (615) 741-2056
	Texas 1-800-252-3439	
Department of Insurance Complaints Resolution, (MC 111-1A) 333 Guadalupe St. (78701) P.O. Box 149091 Austin, TX 78714-9091 1-800-252-3439 (512) 463-6515		Department on Aging P.O. Box 12786 (78711) 1949 IH 35 South Austin, TX 78741 1-800-252-9240 (512) 444-2727
	Utah 1-800-439-3805 (801) 538-3910	
Insurance Department Consumer Services 3110 State Office Bldg. Salt Lake City, UT 84114-6901 1-800-439-3805 (801) 538-3805		Division of Aging and Adult Services 120 North 200 West Salt Lake City, UT 84103 1-800-606-0608
	Vermont 1-802-828-3302	
Dept. of Banking & Insurance Consumer Complaint Division 89 Main Street, Drawer 20 Montpelier, VT 05620-3101 (802) 828-3302		Dept. of Aging & Disabilities Waterbury Complex 103 S. Main Street Waterbury, VT 05671-2301 (802) 241-2400

Insurance Departments	Insurance Counseling	Agencies on Aging
Bureau of Insurance 1300 E. Main Street Richmond, VA 23219 (804) 371-9691 1-800-552-7945	**Virginia** 1-800-552-3402	Dept. for the Aging 700 Centre, 10th Floor 700 E. Franklin Street Richmond, VA 23219-2327 1-800-552-3402 (804) 225-2271
Insurance Department Kongens Gade No. 18 St. Thomas, VI 00802 (809) 773-6449 ext. 248	**Virgin Islands** (809) 774-2991	Senior Citizen Affairs Div. Dept. of Human Services 19 Estate Diamond Fredericksted St. Croix, VI 00840 (809) 772-0930
Insurance Department 4224 6th Ave., SE, Bldg. 4 P.O. Box 40256 Lacey, WA 98504-0256 1-800-397-4422 (360) 407-0383	**Washington** 1-800-397-4422	Aging & Adult Services Admin. Dept. of Social & Health Services P.O. Box 45050 Olympia, WA 98504-5050 (360) 586-3768
Insurance Department Consumer Service 2019 Washington St., E P.O. Box 50540 Charleston, WV 25305-0540 (304) 558-3386 1-800-642-9004 1-800-435-7381 (hearing impaired)	**West Virginia** 1-800-642-9004 (304) 558-3386	Commission on Aging State Capitol Complex Holly Grove 1900 Kanawha Blvd., East Charleston, WV 25305-0160 (304) 558-3317
Insurance Department Complaints Department P.O. Box 7873 Madison, WI 53707 1-800-236-8517 (608) 266-0103	**Wisconsin** 1-800-242-1060	Board on Aging and Long-Term Care 214 N. Hamilton St. Madison, WI 53703 1-800-242-1060 (608) 266-8944
Insurance Department Herschler Building 122 W. 25th Street Cheyenne, WY 82002 1-800-438-5768 (307) 777-7401	**Wyoming** 1-800-856-4398	Division on Aging Hathaway Building 2300 Capitol Ave., Room 139 Cheyenne, WY 82002 1-800-442-2766 (307) 777-7986

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